Out of State Verification of Registration / Certification / Licensure as a Mental Health Counselor

Applicant Name: _____ Birthdate: _____

I, _____ ,Secretary of _____ ,
OFFICIAL NAME OF BOARD

hereby certify that _____

was granted state:
Registration/Certificate/License
Number: _____ to practice _____

in the State of _____ on the _____ day of _____ , 20 _____.

Legal/Disciplinary Action: ☐ Yes ☐ No

If Yes, explain: _____

_____

On the basis of: _____

Did applicant take and pass the NBCC Exam?	☐ Yes ☐ No	Passing Score: _____
	☐ Yes ☐ No	100 hours Postgraduate Supervision
	☐ Yes ☐ No	3000 hours Postgraduate Professional Experience **1200 hours must be on an individual basis**
	☐ Yes ☐ No	36 months full time counseling

Status of License: ☐ Current Expiration Date: _____

☐ Expired Date _____

S E A L

_____
OFFICIAL NAME OF BOARD PHONE

_____
SECRETARY

_____
DATE CERTIFICATION PREPARED

Return to: **Department of Health**
Counselor Programs
PO Box 47869
Olympia, WA 98504-7869